1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12739

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12743

1. DECEASED-NAME (Type or Print) First	Middle	Lost
FRANK	PAUL	ALBANESE

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Month Doy Year: Sept. 11 1969 — 2b. HOUR: M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.
Male	White	MARCH 16, 1906	63 YRS.				

2c. DATE PRONOUNCED DEAD: Month Doy Year: September 11, 1969 — 2d. HOUR: 11:25 A. M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Md	USA		CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
ELKTON	112 Blueball Avenue	CAB DRIVER	CAB

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Elkton	YES ☒ NO ☐	112 Blueball Avenue

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
CHRISTOPHER		ALBANESE	UNK		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	216-05-3950	PAULINE MACKIE	CALVERT, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 955 X
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Year HOUR A.M. ? P.M. ? 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
		Shot self

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	home	112 Blueball Ave.	Elkton	Cecil	Md.

22a. **I certify** thot I took chorge of the remoins described above, held an Autopsy ☒, Inspectian ☐, Inquiry ☐, ond in my apinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: September 11, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	SEPT. 14 1969	ELKTON	ELKTON CECIL Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME	ELKTON Md	DATE SEP 15 1969	Wilmerley Judge

VR A15ME (5)
10M REV. 1/68

10 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

12740

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12744

1. DECEASED-NAME (Type or Print) First: Gwen	Middle:	Last: Blanchfield	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: 9	Day: 22	Year: 1969	2b. HOUR: 10:12 a.m.			
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: Nov. 6, 1928	6. AGE (In years last birthday): 40 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.			2c. DATE PRONOUNCED DEAD Month: 9	Day: 22	Year: 1969	2d. HOUR: 10:12 a.m.
7a. BIRTHPLACE (State or foreign country): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.						
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Nurse R.N.	12b. KIND OF BUSINESS OR INDUSTRY: Nursing						
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: 3 Kent Rd.					
14. FATHER'S NAME First: James	Middle:	Lost: Thomas	15. MOTHER'S MAIDEN NAME First: Ellen	Middle:	Last: Palmer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 188-22-7773	17. INFORMANT ADDRESS: George F. Blanchfield, 3 Kent Rd. Elkton, Md							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory insufficiency during abdominal surgery

614X

~~DUE TO, OR AS A CONSEQUENCE OF~~ for hystero-salpingo-oophorectomy

Conditions, if ony, which gove rise to immediote couse (a), stating the underlying couse lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Obesity

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, form, street, factary, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot I took chorge of the remoins described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], ond in my opinion deoth resulted from: Noturol couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined monner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: 9/23/69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9/25/69	Elkton Cemetery	Elkton		Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	SEP 29 1969	Charles Jagga

VR A15ME (5)
10M REV. 1/68

61 1 2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12741

CERTIFICATE OF DEATH

12745

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Frank A. Boggs			Sept.	1	1969	6:40 A. M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	Feb. 6, 1894	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
W. Va.	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Calvert	Calvert Manor Nursing Home	Sawyer	Lumber

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Cecil	Elkton	YES ☐ NO ☒	R.D. # 1

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Allan Boggs			Rebecca Laudermilk		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WW I	232-14-9639	Mearl F. Boggs	R.D. # 2 Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart failure

250.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c) Senility

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) 6 mos. (b) 25 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 62, to Sept 1 19 69, that (I) (we) last saw the deceased alive on Sept 1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Ernest W. Seiter	M.D.	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	9/2/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Ernest W. Seiter	28 West Cherry St. Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/4/69	North East Methodist	North East Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home	Box 250 North East, Md.	SEP 5 1969	Charles Judge

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12742 — 12746

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires thot the deoth certificote be executed within 24 hours after death. Poge 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: William	Middle: Alfred	Lost: Briscoe	2o. DATE OF DEATH: Month: September	Day: 24 / Year: 1969
2b. HOUR	M				
3. SEX	Male				
4. RACE	Negro				
5. DATE OF BIRTH	July 4, ~~1885~~ 1907				
6. AGE (In years last birthday)	~~81~~ 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7o. BIRTHPLACE (State or foreign country)	Md.				
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.				
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐					
9. COUNTY OF DEATH	Cecil				Md.
10. CITY OR TOWN OF DEATH	Elkton				
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	Union Hospital				
12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Laborer				
12b. KIND OF BUSINESS OR INDUSTRY	Farming				
13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE	Md.				
13b. COUNTY	Kent				
13c. CITY OR TOWN	Galena				
13d. INSIDE CITY LIMITS? YES ☐ NO ☒					
13e. STREET AND NUMBER	-----				
14. FATHER'S NAME First	George	Middle: A.	Lost: Briscoe		
15. MOTHER'S MAIDEN NAME First	Charity	Middle: E.	Lost: Carroll		
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	No	(If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.	213-14-7746				
17. INFORMANT Address	George A. Briscoe, Jr. Galena, Md. 21635				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	1 hr
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebro Vascular Accident	2 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Arter Sclerosis & Diabetes	2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 436.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22o. **I certify** that (I) (this hospital) attended the deceased from Aug., 1967, to Sept., 1969, thot (I) (we) last saw the deceased alive an _____ 19___, and thot in (my) (our) opinion death occurred an the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)	Joseph G. Lanzi, M. D.	22e. ADDRESS	721 Bridge St. Elkton, Maryland 21921

23o. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	Sept. 27, 1969	23c. NAME OF CEMETERY OR CREMATORY	Olivet Hill Cemetery
23d. LOCATION (City or Town) (County) (State)	Galena, Kent, Md.				
24. FUNERAL DIRECTOR ADDRESS	Edward Fellows & Son. Millington, Md. 21651	25o. REC'D BY REGISTRAR DATE	SEP 29 1969	25b. REGISTRAR'S SIGNATURE	J. Charles Judge

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12743 — 12747

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: William	Middle: J.	Last: Coalson	2a. DATE OF DEATH: Month Sept. Day 2, Year 1969	2b. HOUR: 6 P. M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: July 15, 1922	6. AGE (In years last birthday): 47 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Schmokin, Pa.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Assemblyman Gen. Motors	12b. KIND OF BUSINESS OR INDUSTRY: Auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Pa.	13b. COUNTY: Del.	13c. CITY OR TOWN: Boothwyn	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 901 Thornton Avenue		
14. FATHER'S NAME First: Grant	Middle	Last: Coalson	15. MOTHER'S MAIDEN NAME First: Ruth	Middle	Last: Krater	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): yes	(If yes give war or dates of service): WW 2	16b. SOCIAL SECURITY NO.: 191-14-7822	17. INFORMANT: Mrs. Lorene Coalson	Address: Boothwyn, Pa.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio- Vascular Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 min.

DUE TO, OR AS A CONSEQUENCE OF

(b): C.V.A. c/ Cerebral Hemorrhagia — 4 days

DUE TO, OR AS A CONSEQUENCE OF

(c): Hypertension c/ H.C.V.D. — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Left. Hemiplegia; Electrolytes imbalance; Uremia; Hematemesis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) — 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 — 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ] — 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) — 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-29-, 1969, to 9-2-, 1969, that (I) (we) last saw the deceased alive on 9-2-, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Luis M Cuza M D — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 9-3-1969

22d. PHYSICIAN'S NAME (Type): Luis M. Cuza, M.D. — 22e. ADDRESS: 322 E. Cecil Ave. North East Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: Sept. 6, 1969	23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery	23d. LOCATION (City or Town): Broomall	(County): Del.	(State): Pa.
24. FUNERAL DIRECTOR: Piccini Funeral Home	ADDRESS: Elkton Md	25a. REC'D BY REGISTRAR DATE: SEP 5 1969	25b. REGISTRAR'S SIGNATURE: [illegible]		

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12744 12748

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Carolyn	Middle: Elizabeth	Last: Connelly	2a. DATE OF DEATH Month: Sept. Day: 13 Year: 1969
2b. HOUR: M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 6--8--1911	6. AGE (In years last birthday): 58 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): N. C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Co. Md.
10. CITY OR TOWN OF DEATH: Rising Sun, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.F.D. # 1	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): School Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Elementary
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: Rising Sun	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: R.F.D.# 1			
14. FATHER'S NAME First: John	Middle: ---	Last: Suddreth	15. MOTHER'S MAIDEN NAME First: Corneillia Middle: ------ Last: Bowman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213-38-5011	17. INFORMANT: Mr. Paul Connelly	Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infartion
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary sclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs. / 2 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 6-10, 1969, to 9-13, 1969, that (I) (we) last saw the deceased alive on 9-11 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Neil R Taylor Jr. DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] 22c. DATE SIGNED: 9-16-69

22d. PHYSICIAN'S NAME (Type): Neil R. Taylor Jr. M.D. 22e. ADDRESS: Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9-16-1969	23c. NAME OF CEMETERY OR CREMATORY: Brookview Cem.	23d. LOCATION (City or Town): Rising Sun	(County): Cecil	(State): Md.
24. FUNERAL DIRECTOR: Solomon E McMullen	ADDRESS: Rising Sun, Md.	25a. REC'D BY REGISTRAR DATE: SEP 19 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge		

VR A15(1)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH

12745 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12749

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: REUBEN	Middle: HAMILTON	Last: DEVINE	2a. DATE KNOWN ☒ OF DEATH ESTIMATED ☐ Month: 9	Day: 20	Year: 19 69	2b. HOUR: 11:30 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: SEPT. 3 1909	6. AGE (In years last birthday): 60 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 9	Day: 20	Year: 19 69	2d. HOUR: 11:40 AM
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: CECIL Md.				
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): UNION HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): ELECTRICAL	12b. KIND OF BUSINESS OR INDUSTRY: ELECTRIC				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: CECIL	13c. CITY OR TOWN: ELKMORE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RD #1			
14. FATHER'S NAME First: JOHN	Middle: F.	Last: DEVINE	15. MOTHER'S MAIDEN NAME First: ANNETTE	Middle: VAN SANT	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-01-4620	17. INFORMANT ADDRESS: REUBEN F. DEVINE - RD #1 ELKTON Md.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Undet.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture af injury in Part 1 ar Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, affice building, etc.)	21f. LOCATION Street ar R.F.D. Na. / City ar Town / County / State

22a. **I certify** that I took chorge of the remains described above, held an Autapsy ☐, Inspectian ☒, Inquiry ☐ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: T. Alan D. Johnson M.D.

EXAMINER'S NAME (Type): Tillman D Johnson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, tawn, or county): Elkton, Md.

22b. DATE SIGNED: 9-21-69

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: SEPT. 24, 1969	23c. NAME OF CEMETERY OR CREMATORY: IMMACULATE CONCEPTION	23d. LOCATION (City or Town) (County) (State): CHERRY HILL Cecil Md.	
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME	ADDRESS: Main St ELKTON, Md	25a. REC'D BY REGISTRAR DATE: SEP 23 1969	25b. REGISTRAR'S SIGNATURE: [illegible]	

VR A15ME (5)
10M REV. 1/68

1

12746

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: MAUDE	Middle: ANNA	Last: GRIFFITH	2a. DATE OF DEATH Month: SEPT Day: 23 Year: 69
2b. HOUR: 10 30 PM			
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: OCT 29 1888	6. AGE (In years last birthday): 80 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): PENNA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: CECIL Md.
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): UNION HOSPITAL	12a. USUAL OCCUPATION (Kind of wark dane during mast of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: AT HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD	13b. COUNTY: CECIL	13c. CITY OR TOWN: ELKTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 116 MAFFITT ST			
14. FATHER'S NAME First: CLEMENT	Middle:	Last: THOMAS	15. MOTHER'S MAIDEN NAME First: EDITH	Middle:	Last: MYERS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215-32-7463	17. INFORMANT Address: HOSPITAL RECORDS ELKTON MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MASSIVE CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO, OR AS A CONSEQUENCE OF

(b): CHRONIC HYPERTENSIVE CV DISEASE — SEVERAL YEARS

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditians, if any, which gave rise to immediote cause (a), stating the underlying cause last. 4122

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Yeor 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.)		
21d. INJURY OCCURRED While at wark ☐ Not while at wark ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City ar Town	County / State

22a. **I certify** that (I) (this haspital) attended the deceased fram JAN. 10, 19 62, ta SEP 23, 19 69, that (I) (we) last saw the deceased alive an SEPT 23 1969, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Henry V. Davis	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐		22c. DATE SIGNED: 9/23/69	
22d. PHYSICIAN'S NAME (Type): HENRY V. DAVIS M.D.	22e. ADDRESS: CHESAPEAKE CITY MD			
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9-27-69	23c. NAME OF CEMETERY OR CREMATORY: ATGLEN PRESBYTERIAN	23d. LOCATION (City or Town): ATGLEN	(County): PENNA (State):
24. FUNERAL DIRECTOR: [illegible] Home for Funerals	ADDRESS: Elkton, Md	25a. REC'D BY REGISTRAR DATE: SEP 26 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12747 12751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	George	Middle W	Last Hammond
2a. DATE OF DEATH Month Day Year	September 5, 1969		2b. HOUR A.M. P.M. 8:10 M
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	8/13/97		
6. AGE (In years last birthday)	72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	Maryland		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐			
9. COUNTY OF DEATH	Cecil Md.		
10. CITY OR TOWN OF DEATH	Elkton		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Union Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	State Roads Commission		
12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland		
13b. COUNTY	Cecil		
13c. CITY OR TOWN	Elkton		
13d. INSIDE CITY LIMITS? YES ☒ NO ☐			
13e. STREET AND NUMBER	252 West High Street		
14. FATHER'S NAME First	James	Middle	Last Hammond
15. MOTHER'S MAIDEN NAME First	Mary	Middle	Last Goodnow
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.	218-14-6713		
17. INFORMANT	A Mrs. Edna Hammond (wife)	Address	Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Edema	4-Days
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive Heart Failure	5- Months
DUE TO, OR AS A CONSEQUENCE OF (c)	Carcinoma of Left Lung	5-Months

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) this hospital attended the deceased from 5/26/ , 19 69 to 9/5/ , 19 69 , that (I) (we) last saw the deceased alive on 9/5/ 1969, and that in (my) (our) opinion death occurred on the date and haur and from the causes stated abave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	James L Johnson M.D.	DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 9/5/69
22d. PHYSICIAN'S NAME (Type)	James L. Johnson M.D.	22e. ADDRESS	245 E. High St., Elkton Cecil Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County)	(State)
Burial	9/9/69	Cherry Hill Meth. Cemetery	Cherry Hill, Cecil	Md.
24. FUNERAL DIRECTOR ADDRESS	Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	25a. RECD BY REGISTRAR DATE	SEP 11 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

VR A15 (4) 45M · 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4123

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12748

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12752

1. DECEASED-NAME (Type or Print) First	Middle	Lost
Harry	Richard William	Horn

2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐ Month 9 Doy 21 Yeor 1969
2b. HOUR Est. 8 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.
Male	White	Oct. 22, 1888	80 YRS.				

2c. DATE PRONOUNCED DEAD Month 9 Doy 21 Yeor 1969
2d. HOUR 12:40 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Ohio	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	303 Landing Lane	Salesman	---

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Cecil	Elkton	YES ☒ NO ☐	303 Landing Lane

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Max		Horn	Amelia		Dolke

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	309-10-6191A	Mrs. Anita Heath, Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** thot I took chorge of the remoins described obove, held on Autopsy ☐, Inspection ☑, Inquiry ☑, ond in my opinion deoth resulted from: Notural couses ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Tillman D. Johnson M.D.
EXAMINER'S NAME (Type) Tillman D. Johnson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ADDRESS(Street, city, town, or county) Elkton, Md.
22b. DATE SIGNED 9-21-69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/26/69	Riverside Cemetery	Defiance, Ohio

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	SEP 29 1969	Dorothy Jones

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12749 12753

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 haurs after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
CARL	HERBERT	JAMISON	9	29	69	3:10 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
MALE	WHITE	FEB. 20, 1903	66 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
PENNA	U.S.A.		CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
ELKTON	UNION HOSPITAL	ENGINEER	WESTINGHOUSE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	CECIL	EARLEVILLE	YES ☒ NO ☐	130 MIDWAY DRIVE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CARL	S.	JAMISON	EMILIE		DAVIS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		184-05-1092	MRS. MARGARET E. JAMISON	EARLEVILLE Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MESENTERIC THROMBOSIS	12 HOURS
DUE TO, OR AS A CONSEQUENCE OF (b)	CHRONIC ARTERIO-SCLEROTIC HEART DISEASE	SEVERAL YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)		

4123 Conditians, if any, which gave rise to immediate cause (a), stoting the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) (WERE STUDIED)
DECEASED WAS ADMITTED TO HOSPITAL HIMSELF AS PATIENT DR. W. OBENSHAIN - CECILTON M.D. HAS TREATED PT MANY YEARS HEARS GOOD RECORDS WHICH

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from SEP. 28, 1969, to SEPT 29, 1969, that (I) (we) last saw the deceased alive on SEPT. 28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Henry V. Davis M.D.		☒	☐	☐	9/29/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
HENRY V. DAVIS MD	CHESAPEAKE CITY MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	OCT. 2, 1969	GLENWOOD MEM. GDNS.	BROOMALL	DEL. CO.	PA.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PIDDIN FUNERAL HOME	ELKTON Md.	SEP 30 1969	Charles Jones

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12750

12754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1. DECEASED-NAME (Type or print) First	James	Middle M.	Last Jones
2o. DATE OF DEATH Month Day Year	September 28 1969		2b. HOUR 5:30 a.m.
3. SEX	Male		
4. RACE	Negro		
5. DATE OF BIRTH	November 2, 1906		
6. AGE (In years last birthday)	62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7o. BIRTHPLACE (State or foreign country)	Penna.		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒			
9. COUNTY OF DEATH	CECIL Md.		
10. CITY OR TOWN OF DEATH	Perry Point		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	VA Hospital		
12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Laborer		
12b. KIND OF BUSINESS OR INDUSTRY	Unknown		
13o. USUAL RESIDENCE (Where deceosed lived if institution: Residence before odmission) STATE	Penna		
13b. COUNTY	Chester		
13c. CITY OR TOWN	Oxford		
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐		
13e. STREET AND NUMBER	540 New Street		
14. FATHER'S NAME First	Monroe	(Unk)	Jones
15. MOTHER'S MAIDEN NAME First	Sarah	(Unk)	Harrison
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	Yes	(If yes give war or dates of service) WW 2	
16b. SOCIAL SECURITY NO.	198 03 9788		
17. INFORMANT Address	VA Hospital Records, Perry Point, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Malignant cachexia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1621

Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic carcinoma of left lung with

DUE TO, OR AS A CONSEQUENCE OF (c) metastases to brain.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While ☐ Not while ☐ ot work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Va	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22a. I certify that (XX) (this hospital) attended the deceased from June 19, 1969, to Sept. 28, 1969 and that in (XX) (aur) apinian death accurred an the date and haur and from the causes stated abave, (XX) we) (did) view the bady after death.

22b. SIGNATURE	A. L. Mooney, M.D.	DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED 9-28-69
22d. PHYSICIAN'S NAME (Type)	A. L. MOONEY, M.D.	22e. ADDRESS	c/o VA Hospital, Perry Point, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Burial Oct 2 '69	23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	23d. LOCATION (City or Town) (County) (State)	Oxford (Chester) Penna.
24. FUNERAL DIRECTOR	ADDRESS Ralph M. Reed RALPH M. REED RISING SUN, MARYLAND	25o. REC'D BY REGISTRAR OCT 3 1969	25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12751

CERTIFICATE OF DEATH

12755

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	JOHN / S. / KEITHLEY	2a. DATE OF DEATH Month Day Year	SEPTEMBER 18, 1969
2b. HOUR	6:50 P.M.		
3. SEX	MALE	4. RACE	WHITE
5. DATE OF BIRTH	DECEMBER 9, 1890	6. AGE (In years last birthday)	78 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	CECIL Md.
10. CITY OR TOWN OF DEATH	ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	UNION HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	FARMER	12b. KIND OF BUSINESS OR INDUSTRY	FARM.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) – STATE	Md.	13b. COUNTY	CECIL
13c. CITY OR TOWN	ELKTON	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET AND NUMBER	RD #5		
14. FATHER'S NAME First / Middle / Last	JAMES / J. / KEITHLEY	15. MOTHER'S MAIDEN NAME First / Middle / Last	SUSAN / R. / HEATH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	220-34-7317A
17. INFORMANT Address	MARY CONNER KEITHLEY		ELKTON Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hours
DUE TO, OR AS A CONSEQUENCE OF
(b) Myelofibrosis — 3 years
DUE TO, OR AS A CONSEQUENCE OF
(c)

209X

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic Heart disease & Anemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 66, to Sept 18, 19 69, that (I) (we) last saw the deceased alive on Sept 18 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	Williford Eppes MD	DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED 9/18/69
22d. PHYSICIAN'S NAME (Type)	WILLIFORD EPPES	22e. ADDRESS	327 E. MAIN ST. NEWARK, DEL.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	9-21-69	BETHEL CEMETERY	CHESAPEAKE CITY	Md.
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
DIPPIN FUNERAL HOME	ELKTON, Md	SEP 22 1969	Charles Judge	

VR A15V4
30M REV. 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forworded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremotion, or removol, and in any event within 72 hours after death.

12752

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12756

1. DECEASED-NAME (Type or Print) First / Middle / Last: Isaiah King								2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Sept. Doy 7 Year 1969			2b. HOUR M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Feb. 4, 1913	6. AGE (In years last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN		2c. DATE PRONOUNCED DEAD: Month Sept. Doy 7 Year 19 69			2d. HOUR 10:50 A. M
7a. BIRTHPLACE (State or foreign country): Olka.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.								
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY: Road Building								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: R.D. # 3							
14. FATHER'S NAME First / Middle / Last: William King		15. MOTHER'S MAIDEN NAME First / Middle / Lost: Lenore Cole									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes	(If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 188-07-4882	17. INFORMANT: Anna Lee Shenton	ADDRESS: Church Creek Cambridge, Md.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CEREBRAL ANOXIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

(b): CEREBRAL HEMORRHAGE — 1 hour

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 431.9

DUE TO, OR AS A CONSEQUENCE OF

(c): GENERALIZED ARTERIOSCLEROSIS — 2 weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** thot I took chorge of the remoins described obove, held on Autopsy [ ], Inspection [ ], Inquiry [ ], ond in my opinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Rolando A. Najera M.D.

EXAMINER'S NAME (Type): Rolando A. Najera

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: 9/7/69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 10, 1969	North East Methodist	North East Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home Paul R. Grant	Box 250 North East, Md.	DATE SEP 10 1969	Charles Judge

VR A15ME (5) 10M REV. 1/68

Item2a FilmG417
9/29/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12753 (upper left) 12757 (upper right)

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: RUTHIE	Middle: FAY	Lost: KIRK	2a. DATE KNOWN OF DEATH ESTIMATED	Month: 9	Day: 17	Year: 1969
2b. HOUR: M							
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 10-12-16	6. AGE (in years last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
2c. DATE PRONOUNCED DEAD: Month: September	Day: 17.	Year: 1969	2d. HOUR: 9:30 P.M.				
7a. BIRTHPLACE (State or foreign country): TENN	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: CECIL Md.				
10. CITY OR TOWN OF DEATH: Northeast	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 107 W. High Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: Northeast	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 107 W. High Street			
14. FATHER'S NAME First: JAMES	Middle: PATRICK	Lost	15. MOTHER'S MAIDEN NAME First: MOLLIE	Middle	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: ANNA MAE MONGER	ADDRESS: RISING SUN, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4124
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic emphysema with cor pulmonale

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I taak charge af the remains described above, held an Autapsy ☒, Inspectian ☐, Inquiry ☐, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Chas S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)
22b. DATE SIGNED: September 18, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 9/19/69	23c. NAME OF CEMETERY OR CREMATORY: WEST NOTTINGHAM	23d. LOCATION (City or Town) (County) (State): COLORA CECIL, MD.	
24. FUNERAL DIRECTOR ADDRESS: Ralph M Reed RALPH M. REED, RISING SUN, MD.	25a. REC'D BY REGISTRAR DATE: SEP 22 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge		

VR A15ME (5)
10M REV. 1/68

4 1

12754

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12758

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Virginia	C.	Kistenmacher	Sept 15 1969	9:35P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	4/22/~~10~~ 1909	~~XXX~~ 60 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ~~XX~~ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Penna	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hsopital	hswf	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Md.	Cecil	Elkton	X	212 Park Circle

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Walter J ~~Xxxxxx~~ Diener	Clara Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Howard Kistenmacher	Elkton, Md. 212 Park Circle,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypoglycemic shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24hurs
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if ony, which gave rise ta immediate cause (o), stoting the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

251X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)
Markedly severe Rheumatoid arthritis, Poss septicemia and shock.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** thot (I) (this hospital) attended the deceased from 1 Sept 68, 19___, to 15 Sept 69, 19___, thot (I) (~~we~~) lost saw the deceased alive on 15 Sept 69 19___, and that in (my) (~~our~~) opinian death occurred on the date ond hour ond from the couses stoted obove, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED
Wallace Obenshain		18 Sept69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Wallace Obenshain, M.D.	Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/19/69	Hillside Cemetery	Roslyn, Phila, Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	SEP 24 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12755

12759

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	Delbert U. Kline	2a. DATE OF DEATH Month / Day / Year	Sept. 30 1969	2b. HOUR	11:40 A.M.
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH	Dec. 15, 1898
6. AGE (In years last birthday)	70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. COUNTY OF DEATH	Cecil Md.				
10. CITY OR TOWN OF DEATH	Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	Union Hospital	12a. USUAL OCCUPATION (Kind of work done during mast of working life, even if retired.)	Automotive Mechanic
12b. KIND OF BUSINESS OR INDUSTRY	Civil Service				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Cecil	13c. CITY OR TOWN	North East
13d. INSIDE CITY LIMITS? YES [XX] NO [ ]		13e. STREET AND NUMBER	115 Jethro St.		
14. FATHER'S NAME First / Middle / Last	Stephen Kline	15. MOTHER'S MAIDEN NAME First / Middle / Last	Margaret Potts		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	Yes	(If yes give war or dates of service)	WW I	16b. SOCIAL SECURITY NO.	214-16-6350
17. INFORMANT	Mrs. Frances R. Kline	Address	115 Jethro St. North East, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF Cecum
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gove rise to immediate cause (a), stoting the underlying couse last.
1530
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / Stote

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 1967, to Present, 19____, that (I) (we) last saw the deceased alive an Sept 29 1969, and that in (my) (~~our~~) opinion death accurred an the dote and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body ofter death.

22b. SIGNATURE	Robert L. Gray M.D.	DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED	OCT 1, 1969
22d. PHYSICIAN'S NAME (Type)	Robert L. Gray	22e. ADDRESS	123 W. High St. Elkton, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	10/3/69	23c. NAME OF CEMETERY OR CREMATORY	North East Methodist
23d. LOCATION (City or Town) (County) (State)	North East Cecil Md.				
24. FUNERAL DIRECTOR	Grant Funeral Home	ADDRESS	Paul Crouch North East, Md.	25a. REC'D BY REGISTRAR DATE	OCT 2 1969
25b. REGISTRAR'S SIGNATURE	Charles Judge				

VR A (5-64) 45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12756

CERTIFICATE OF DEATH

12760

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ROBERT	BERTRAM	LAWRENCE	9	9	69	8:00 am

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Male	White	10-26-13	55 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	Veterans Administration	Rightaway Agent	State Roads

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury		809 Alvin Avenue.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John		Lawrence (D)	Bertha		Mann (D)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW II	215-09-8860	Mrs. Helen J. Lawrence (Wife) Salisbury, Md. VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) chronic auricular fibrillation & congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF (b) Laennec's cirrhosis w/jaundice

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 571.0

Arteriosclerotic heart disease w/

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic urinary tract infection Sacral decubitus ulcers

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO XX	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from July 24, 19 69, to Sept. 9, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Irina Reus				X	9-9-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
IRINA REUS, M.D.	VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 12, 1969	Wicomico Memorial Park	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Holloway Funeral Home, Salisbury, Md.	SEP 15 1969	Charles Lee

VR A15 (4)
45M - 1/69

1

12757

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Ralph	H.	Murphy	Sept.	1	1969	2:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	Cau.	June 30, 1898	71 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Com. Fisherman	Self Employed

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Cecil	Charlestown	YES ☒ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	H.	Murphy	Bertha		McGuirk

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		214-34-3681	Mrs. Betty J. McMullen	Charlestown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure + pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic cardiovascular disease

4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-22, 1964, to 9-1, 1969, that (I) (we) last saw the deceased alive on 9-1 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Jay S. Barnhart Jr.	M.D.	☒	☐	☐	9-1-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Jay S. Barnhart Jr. M.D.	North East, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	Sept. 4, 1969	Charlestown Cemetery	Charlestown	Cecil	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee G. Pattison & Son	Perryville, Md.	SEP 8 1969	Charles Judge

VR A15 (4)
45M - 1-69

1

12758

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12762

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1968

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Alvin	Briscoe	Nickle	Sept.	19	1969	12:40 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	Jan. 24, 1875	94 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Cecil	U.S.A.	WIDOWED [X]	Cecil Co. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Rising Sun, Md.	Calvert Manor Nursing Home	Farmer Ret.	Own Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
Md.	Cecil	Conowingo	NO [X]	R.F.D. # 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Stephen	-------	Nickle	Catherine	------	Bigley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	-------	Charles Nickle Conowingo, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Old age

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4409

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospitol) attended the deceased from May 6, 1947, to 9/19, 1969, thot (I) (we) last saw the deceased olive on 9/12 1969, and thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stated above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Dudley Phillips		[X]	[ ]	[ ]	9/20/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dudley Phillips MD.	Darlington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9--22--69	West Nottingham Cem.	Colora Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lemon & McMullen	Rising Sun, Md	SEP 24 1969	Charles Judge

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12759 12763

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Luther		Postell	9 28 69	500P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	1/24/03	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
S Carolina	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton, Md.	Union Hospital	RET. STOREKEEPER	NEWS STAND

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Chesapeake Cy	YES ☐ NO ☒	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Samuel		Postell	EMMA ~~Annie~~		NO INFO.

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	213-10-9755	Hospital Records	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Rupture of abdominal aorta	5 min?
DUE TO, OR AS A CONSEQUENCE OF (b)	Aneurysm of abdominal aorta	3-4 weeks?
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized arteriosclerosis	8-10 yrs.

441.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary emphysema, A.H.D., Fibrosis cirrhosis, splenomegaly

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	Yes.

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9/27, 1969, to 9/28, 1969, that (I) (we) last saw the deceased alive on 9/28 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I), (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Peter Stavrakis		☒	☐	☐	9/28/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
PETER STAVRAKIS	ELKTON Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10-2-69	SAULDAN CEMETERY	ROBESONVILLE S.C.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
R.T. FOARD FUNERAL HOME	CHESAPEAKE CITY MD	SEP 30 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

12760

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items1&7 Film G417 9/29/69 kk

CERTIFICATE OF DEATH

12764

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Percy	L.	Shook, Jr.	9	16	69	10:25 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	White	6/13/27	42 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
North Carolina	USA		Cecil County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Foreman	Chemical Company

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	Harford	Havre de Grace		313 Wilson St

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Percy	Shook	Sr	Lucy		Davis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	Unk.	Mary Lu Shook	313 Wilson St Havre de Grace Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(b) THROMBOSIS RIGHT CORONARY ARTERY

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 16 Sept, 19 69, to Present, 19____, that (I) (~~we~~) last saw the deceased alive an 16 Sept 19 69 and that in (my) (~~our~~) apinian death accurred an the date and haur and fram the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Robert J Gray	M.D				16 Sept 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
	9/19/69	Bel Air Mem. Gardens	Bel Air	Harford	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Pennington & Sn.	Havre de Grace Md	SEP 19 1969	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the death certificate be executed within 24 hours after death. Page 4 moy be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremotion, or removol, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1X'68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12761 — 12765

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Joseph	James	Smith	September 27, 1969	5:10 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	June 5, 1896	73 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	MARRIED X	Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	VA Hospital, Perry Point, Md.	Laborer-Custodian	Church-School

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Baltimore	Baltimore	YES X NO	5 Whitethorn Way

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph	NMN	Smith	Adelene		Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW I	218 01 6567	VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary edema and bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b) Secondary to congestive heart failure with

DUE TO, OR AS A CONSEQUENCE OF mitral inefficiency

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	VA				

22a. I certify that I (hospital) attended the deceased from March 20, 1968, to Sept. 27, 1969, that (I) (last saw) the deceased alive on [illegible], and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	M.D. / D.O.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. X	22c. DATE SIGNED
					9-27-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. MORRIS	c/o VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/30/69	Holly Hill Memorial Gardens	Baltimore Co., Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Bruzdzinski Funeral Director	1407 Eastern Ave Essex, Md. 21221	SEP 30 1969	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12762 12766

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Elizabeth	Jane	Thompson	September	17,	1969	12:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	April 12, 1903	66 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Pennsylvania	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of wark dane during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Calvert	Calvert Manor Nursing Home	Waitress	Restaurant

13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	Cecil	Elkton		131 Hollingsworth Manor

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edwin	B.	Thompson	Mary	S.	McGowan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	196-26-4346	Warren E. Thompson, Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure,
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Dis. 20 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Stenosis of Aortic Valve
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Nat while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospitol) attended the deceased from _____, 1968, ta 9-17, 1969, that (I) (we) last saw the deceased alive on 9/16/69 19__, and that in (my) (our) opinian death occurred on the dote and hour and from the couses stated above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE	M.D. DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Ernest W. Seiter	M.D.				Sept 17, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Ernest W. Seiter M.D.	28 W. Cherry St. Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/20/69	Bradford Cemetery	Marshallton, Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	SEP 24 1969	Charles Judge

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12763

CERTIFICATE OF DEATH

12767

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
EDWARD	P.	TILLINGHAST JR	9	10	69	8:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	6-23-23	46 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
District of Col.	U. S. A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	Veterans Administration	Mechanic	Air Craft

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Prince George	~~East Pines~~ Riverdale	YES [X] NO [ ]	5806 63rd Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edward	P.	Tillinghast Sr.	Rose		OBrien

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WW II	579-16-8396	VA Hospital Records,	Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Pulmonary Embolus
DUE TO, OR AS A CONSEQUENCE OF
(b) Thrombo-embolic Disease of Lungs and
DUE TO, OR AS A CONSEQUENCE OF
(c) Vascular System

450X

Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (X) (this hospital) attended the deceased from Aug. 29, 19 69, to Sept. 10, 19 69, that (I) (we) (did) (did not) see the deceased alive after and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
A. L. Mooney, M.D.				[X]	9-10-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A. L. MOONEY, M.D.	VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/13/69	Ft. Lincoln Cem.	Colmar Manor, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Nelley Funeral Home, Mt. Rainier, Md.	SEP 15 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (8)
45M - 1/69

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12764

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12768

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: RAYMOND Middle: A. Last: WALMSLEY	2a. DATE OF DEATH Month: SEPTEMBER Day: 5 Year: 1969	2b. HOUR 7:05 A M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: JULY 16, 1906	6. AGE (In years last birthday): 63 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): DEL.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: CECIL Md.
10. CITY OR TOWN OF DEATH: NORTH EAST	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): LUMS ROAD	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): MACHINE OPERATOR	12b. KIND OF BUSINESS OR INDUSTRY: MACHINE
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: CECIL	13c. CITY OR TOWN: NORTH EAST	13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET AND NUMBER: LUMS ROAD
14. FATHER'S NAME First: ARTEMUS Middle: WALMSLEY Last:	15. MOTHER'S MAIDEN NAME First: ANOR Middle: COLE Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-01-7329	17. INFORMANT: LAURA V. WALMSLEY	Address: ELKTON RD 4, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
I42.3
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this haspital) attended the deceased from May, 1969, to Sept, 1969, that (I) (we) last saw the deceased alive on 8-29-1969, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated above, ~~(I) (we) (did)~~ (did nat) view the bady after death.

22b. SIGNATURE: T. D. Johnson M.D. DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 9-6-69	
22d. PHYSICIAN'S NAME (Type): T.D. Johnson M.D	22e. ADDRESS: 123 Singerly Ave, Elkton, Md		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9/8/69	23c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY	23d. LOCATION (City or Town) (County) (State): ELKTON CECIL Md.	
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME	ADDRESS: ELKTON Md	25a. REC'D BY REGISTRAR DATE: SEP 8 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

VR A15 (4)
30M REV. 1/68